DOCUMENT RESUME

ED 379 276 SP 035 809

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TITLE Keeping Reform Alive: Teachers, Physicians and Shared Decision Making.
PUB DATE Nov 94
NOTE 24p.; Paper presented at the Annual Meeting of the American Educational Studies Association (Chapel Hill, NC, November 1994).
PUB TYPE Speeches/Conference Papers (150) -- Viewpoints (Opinion/Position Papers, Essays, etc.) (120)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Educational Change; Elementary Secondary Education; Higher Education; *Hospitals; *Medical Services; *Participative Decision Making; *Physicians; Quality Control; School Restructuring; Teacher Role; Teachers; Total Quality Management
IDENTIFIERS *Continuous Quality Improvement; *Reform Efforts

ABSTRACT

Shared decision making (SDM) as an element of educational reform promises enhanced quality outcomes and appeals to educators who see virtue in the idea of people coming together to plan what is best for themselves and their students. Analyses have shown, however, that school councils implementing SDM rarely tackle operational classroom decisions or school decisions that impact on the classroom. The case can be made that hospital reform or restructuring contains several elements that are identical to elements that are central to contemporary school reform. Hospital reform efforts are called continuous quality improvement (CQI). Contemporary reform is an effort to create more flexible, responsive organizations that achieve better results. Both hospitals and schools now employ strategies to involve parents and families to assist in their efforts. Both institutions have tried to become more personal places, more client-centered, more interdisciplinary, and more decentralized. While CQI has been viewed by some physicians as an attack on their profession, a movement to improve patient care by local creation (as opposed to commercially or medical speciality board-prepared) of standardized best practice care plans (called critical paths) has been more acceptable to physicians and concurrently achieves CQI goals. This critical path approach could be used to reorient educational reform. (Contains 56 references.) (JDD)

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KEEPING REFORM ALIVE: TEACHERS, PHYSICIANS AND SHARED DECISION MAKING

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November, 1994

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KEEPING REFORM ALIVE; TEACHERS, PHYSICIANS, AND SHARED DECISION MAKING

Richard Ognibene

Shared Decision Making and School Change

School restructuring, the reform movement that followed the legislated change approach produced by A Nation at Risk in 1993, continue to inspire educators to seek a systematic overhaul of the major components of the American school system. Although thoughtful critics caution against the naive enthusiasm restructuring seems to encourage (Tyack, 1990; Tye, 1992; and Clark & Astuto, 1994), the reform movement endures, sustaining hope that significant improvement in schools might result.

No aspect of restructuring has been more prominent than site based management and the sharing of decision making (SDM) authority with teachers and others (eg., parents) as a necessary and logical consequence of that shift. Indeed, SDM is often thought to be synonymous with restructuring, an inaccurate equation of part of reform strategy with an approach to school improvement that is theoretically more comprehensive. It is not difficult, however, to explain the pre-eminence of SDM. In the first place, SDM is similar to the prevalent assumptions behind recent management theories such as total quality management, corporate reengineering, and the concept of the learning organization (Walton, 1986; Hammer & Champy, 1993; & Senge, 1990). Each of these approaches promises enhanced quality outcomes no matter what goal or service the organization produces. Second, SDM has the obvious potential to address a major issue in the life of teachers, namely, that

teaching is "not quite" a profession (Darling - Hammond & Goodwin, 1993). Finally, SDM appeals to optimistic educators everywhere who see self-evident virtue in the idea of good people coming together to plan to do what is best for themselves and their students (Carnegie Forum, 1986; Glickman, 1990).

As a result, to continue to hope that restructuring will succeed requires one to also hope that a key component, SDM, will be unequivocally successful. Unfortunately, this does not seem to be the case, as several observers have noted in recent years. As early as 1989 when an initial synthesis of research on school-based management appeared, the finding was reported that school councils, the typical vehicle for implementing SDM, rarely tackled instructional issues or even second-order changes related to them (David, 1989). This was significant because as Conley and Bacharach (1990) note, "(r)esearch on teachers' working conditions suggests that teachers clearly want the greatest influence over **operational classroom decisions**, including such areas as what to teach, how to teach, and the selection of textbooks" (p. 542). Teachers also want to be able to influence school decisions that impact on the classroom such as "how children are assigned to classes, how teachers are assigned to classes, and how students are disciplined and promoted" (Conley & Bacharach, 1990, p. 543). A second review of research on SDM done two years later also supported the finding that school councils typically did not deal with those kinds of issues (Conley, 1991).

The initial questions raised by these early reviews of the efficacy of SDM have not been satisfactorily answered by more

recent studies. School restructuring shares a belief with manufacturing and service industries that reform activities must affect processes that are fundamental to the achievement of quality results by the organization (Schlechty, 1990). In schools, this means improving teaching and learning activities, areas that were largely unaffected in 1992 study of 32 schools in a nationally prominent restructuring district with a high emphasis on SDM. Half of the schools in this study were identified as heavily involved in SDM yet they continued to feature teacher dominated instructional approaches, little collaborative work among students or among teachers, and few efforts at cross disciplinary curriculum integration. Teacher and subject matter approaches to instruction prevailed as did the norm of teacher autonomy (Taylor and Teddlie, 1992). Additional studies by Smith (1993) and Firestone (1993) affirm the lack of change in classrooms as a result of school district support of restructuring generally and SDM in particular.

These findings take the mystery out of the title question "Shared Decision Making About What?" used by Carol Weiss to report the results of her analysis in 1993. Data from twelve high schools from eleven states were collected and analyzed over a two and one-half year period. Half of the schools were SDM schools, the rest were not. Two significant differences appear when the two sets of schools were compared: (1) the SDM schools spent more time discussing the decision making process itself; (2) the non-SDM schools spent more time discussing discipline issues. In all other areas involving curriculum, pedagogy, and student concerns,

there were no differences on the amount of attention paid to these issues in either set of schools. The claims made that SDM would encourage a creative, teacher led curriculum and instruction focus, and would orient teachers to a more professional control of their practice, were not evident in the results that Weiss displayed.

Two observations from quite different sources conclude this survey of SDM and school change. The first, a sophisticated analysis of work complexity by Brian Rowan (1994), suggests that changes like SDM encroach on an embedded set of occupational duties and relationships and that insufficient attention has been paid to the consequences of substantially altering them. "As a result," Rowan concludes, "school restructuring is often confined to changing teachers' work only at the margins . . . (p. 13).

The second observation comes from "Lou Romano," a pseudonym for a 61 old year teacher from northern New Jersey whose "ordinary career" was profiled by Gene Maeroff (1994). For Romano, school reform is "a figment of someone's imagination" (p. 17). According to Romano, "'Curriculum and teaching are basically as they were 10, 20 years ago. There's been no reform movement that I know of'" (p. 18). Romano is cynical about SDM and believes that committees involved in this activity are used merely to validate the conclusions already made by administrators. This "doesn't make sense," Romano says. "You've got to go with the people in the trenches - the teachers. They're the ones who are with the kids every day" (p. 18).

To the extent that SDM is an essential aspect of

restructuring, the information presented above suggests that hope for school reform nay be misplaced. Efforts to reform that do not engage the primary workers in an organization to seek meaningful change will not succeed. If the success of restructuring rests on the ability of reformers to involve more teachers with deeper levels of commitment to the reform, then it may be instructive to examine a similar issue in a different institution. I refer here to the role of doctors in current efforts to restructure hospitals, a topic which this article will address shortly.

School and Hospital Reform

The case can be made that hospital reform, often also called restructuring, contains several elements that are identical to those that are central to contemporary school reform (Ognibene, 1993). An explanation for these similarities is suggested by the common history of organizational developments in both institutions. School systems and hospitals were non-existent or insignificant in America at the beginning of the nineteenth century but emerged as important institutions after mid-century. As both institutions expanded they developed bureaucratic forms of organization that grew more hierarchical, rigid, and impersonal during the twentieth century. Contemporary reform in schools and hospitals is simply an effort to find ways to create more flexible, responsive organizations that achieve better results. The structures, roles and relationships that emerged from the earlier efficiency oriented bureaucratic model no longer seem best suited to solve problems confronting modern organizations (Schlechty, 1990). Restructuring

is essentially a search for substitute systems and processes that will accomplish the organization's goals by motivating internal constituencies to produce the level of quality demanded by external clients.

Schools and hospitals, for example, used to keep families out or relegate them to inconsequential roles so that "experts" within the organization could do their work unimpeded by well meaning but uninformed relatives. In restructured schools, an endless variety of strategies are now employed (and often mandated) to involve parents as partners in the effort to reach students. In restructured hospitals, similar efforts are made to encourage care partners (a relative or significant other) to assist in the treatment of patients during their stay, and to manage their care after discharge. When an organization is focusing on quality outcomes instead of protecting professional turf, it welcomes anyone who can help and pays less attention to traditional role definitions.

Another commonality in school and hospital reform is the effort to overturn conventional structures that serve the needs of the organization better than they serve the needs of the client. This trend is evident in creation of smaller schools (or houses in big ones), integrated curricula based on themes rather than disciplines controlled by departments, group and project based instructional approaches instead of teacher dominated ones, schedules that are substantially altered to permit the accomplishments of student work, and the use of authentic assessments.

In hospitals, this orientation to the client is seen in the

movement to decentralize many clinical and administrative services to the ward rather than wheeling the patient to various departments to be processed by an endless array of people, none of whom knows the person. In a restructured hospital, a patient is cared for by a primary nurse who is in charge of the whole care plan instead of being treated by numerous providers each of whom performs a discrete set of functions. If the restructured hospital has been renovated recently, chances are that the ward will look more like a home than an institution. The educational trends noted earlier were designed to make schools more personal places for learning; analogous development in hospitals were introduced to provide a more patient-centered approach to care. In both institutions, these efforts are clearly attempts to break down the structural rigidities that crept in over time and interfere with the organization's efforts to achieve its client oriented goals.

Like in schools, the great hope of hospital reformers is to create organizations in which empowered employees make more and better decisions at the point where those decisions need to be made. Unlike schools where this reform began ealier and was named site-based management and shared decision making, hospital reformers turned to an existing theory called total quality management based on the work of W. Edwards Deming.

Deming's theory assumes that greater intrinsic worker motivation and higher levels of satisfaction will produce better results and profits when management creates the conditions under which positive worker inclinations are allowed to flourish.

Management's role is to articulate a vision in which the highest level of quality is the goal and to recreate the organization administratively so that bureaucratic barriers to quality disappear. According to Deming, it is the system, not the people, that are responsible for problems in a poorly performing organization. Managers who eliminate fear in the workplace, who transfer authority to teams (not departments) closest to the work site, and who continually provide training for individuals in the technical and interpersonal skills required in modern organizations, will find their organizations prosperous. Management should not establish numerical goals but instead communicate the sense that the organization is in search of continuous quality improvement, which is also another name used to identify this theory. When the organization completely focuses on the customer's demand for quality, rather than internal needs determined by administrative units, customers will respond so favorably that the organization's desire for profit and the self-actualization goals of its employees will be met (Walton, 1986).

In healthcare, the contemporary quality management approach was born with the publication of Donald Berwick's 1989 **New England Journal** article, "Continuous Improvement as an Ideal in Health Care," and reached adolescence with the appearance of his book, **Curing Health Care: New Strategies for Quality Improvement** in 1990. Full maturation of the continuous quality improvement ideal in healthcare came with the publication and use of initial quality improvement standards in 1992 by the Joint Commission on

Accreditation of Healthcare Organizations, with expanded quality standards in force by 1993. The unfavorable current financial climate in many health related fields, along with the accreditation requirement, has produced a deluge of continuous quality improvement literature and the adoption of formal continuous quality improvement (CQI) management programs by approximately 70 percent of the nation's hospitals (The Quality March, 1993).

At the operational level, the most visible sign of CQI at work in a hospital is the creation and use of cross functional teams to solve specific problems identified by an assessment process involving a high percentage of employees from all levels of the organization. Teams are typically composed of five to ten people from various parts of the organization that have some relationship to the issue under review, and are given a specific time frame to gather and analyze data concerning that issue in order to propose solutions. Team members are not selected because of their occupational title but because they are closest to the problem under review. In CQI language, the teams are not simply solving problems, they are creating "opportunities for improvement."

From the very beginning of the CQI movement in hospitals, it was obvious that this managerial approach was alien to the traditional thinking and work style of physicians. It was equally obvious that if CQI only addressed administrative concerns and ignored clinical issues which involved physicians, hospital reform would fail or forever focus on issues that were tangential to the central work of the organization. The accounting and

building management departments might be pleased, for example, if a team proposed cost efficient ways to care for and distribute laundry, but that would contribute little to central issue of delivering higher quality, reduced cost medical care. Ways of involving physicians in these matters had to be found if meaningful hospital reform was to be achieved. In other words, both hospital and school reformers need to address a similar concern if they hope to keep the reform movement alive in their respective institutions.

Continuous Quality Improvement and Physicians

The last twenty-five years have been characterized as a period of increased destabilization in the American healthcare system. The stability of an earlier time was based on the dominance of the medical profession, the community orientation of the locally controlled hospital, and the collaboration of both that produced a subsidy to care for the poor by overcharging those who were well off (Ginzberg, 1990). Although changes affecting all three components are important and connected, the focus here is on physicians and the ways in which their lives are different from the revered historical images associated with their profession. American physicians were, as Paul Starr (1982) wrote, a "sovereign profession;" now they are widely portrayed in the media as greedy, uncaring, unsettled, and appropriately "under the knife" (Angier, 1993; Beck, 1993; Rimer, 1993; Toner, 1994).

It is not necessary to comment on all the causes of this transformation, but two seem especially noteworthy. The first was the spectacular success of twentieth century biomedical research and the ongoing development of medical technology. These developments changed the role of the physician from empathic caregiver to scientist who unfailingly ought to be able to cure the sick. Among the results of this change were the growth of medical specializations, training programs that became longer and more technically focused, and the sense shared by physicians and patients that the art of medicine was practiced less than the science of it. Consumer demands for infallible medicine delivered

by Dr. Welby created tension in the lives of many physicians, uncertainty about new dilemmas in their practice, and anger toward the circumstances and institutions held responsible for these changes (Kaufman, 1993; Konner, 1993). Ironically, the conflicting and often impossible demands made of physicians today are the result of the success of modern medicine for which they are chiefly responsible. For many physicians, this situation is bewildering and depressing.

A second development impacting the lives of physicians was the change in medicine from a calling practiced in private offices and locally controlled hospitals to a vast industry dominated by managed care organizations and acute care hospitals operating as part of regional or national chains. Science and technology were partially responsible for this trend, but an equally important factor was the hope of large profits resulting from the availability of Medicare and Medicaid funds beginning in the mid-1960's. Increased governmental financial support for healthcare, as well as expanded insurance coverage paid by employers led inevitably to demands for medical cost containment.

Beginning in 1983, when Congress passed legislation tying payment for Medicare financed hospital services to the diagnostic related group into which the illness fell, every third party payer of medical costs has intensified its effort to mandate treatment regimens of the lowest possible cost. Since the vast majority of healthcare costs are driven by decisions made by physicians, the last decade has been one long battle between governmental and insurance regulators whose stake in the

larger economic issues are often in conflict with physicians whose training and code of ethics direct them to provide the best possible care for the individual patient (Ginzberg,1990; Konner 1993; Montague, 1994). Although the **Journal of the American Medical Association** suggested that these issues are the "battles to watch in the 1990's" (Eddy, 1993), most physicians think the war is over and that they lost. Younger physicians are being trained to accommodate to these changes; established physicians are angry about them; while others are so disillusioned that they simply stop practicing medicine, a new development in a profession in which early retirement was not a tradition (Belkin, 1993a; 1993b; Winerip, 1994).

Physicians who have experienced the recent past as a period of uncertainty, criticism, and assault on their treasured professional autonomy were not likely to welcome some hospital based management initiative that seemed to be essentially another attack on their profession. This was precisely the reaction of rank and file physicians when continuous quality programs burst onto the hospital scene (Merry, 1990).

Concern about this issue was widely addressed in the quality improvement literature. An effort was made to frame the matter as an organizational problem that could be overcome through intelligent management strategy. Suggestions along this line included the following: hold CQI meetings to educate physicians on the goals, principles, and statistical tools used in quality improvement processes at times that were convenient for them but not the normal hours for managers and trainers;

shorten the training component and minimize the use of industrially based jargon typical of quality improvement programs; find an influential physician in the organization who might be sold on the idea and have that person "champion" the approach among colleagues; hire only physician consultants to introduce CQI to the medical staff; and begin the quality program by attacking solvable issues not directly related to physician practice and celebrate the results widely to motivate physicians to "buy into" this approach (Gaining Physician Involvement, 1992; Lewis, 1993; McCarthy, 1993; O'Rourke, 1993). These were sensible but shallow suggestions that did not really address the principal barriers to physician involvement in CQI.

A more persuasive argument appeared in the CQI literature, written primarily by physicians, that associated the quality movement with the scientific tradition in medicine. Physician-researchers saw the possibility of using the CQI approach as a means to reduce variations in clinical practice that generated negative publicity from regulators and concern from practitioners themselves. Gathering data and assessing what treatment plans work better and improving those even more was congruent with the essential passion shared by most physicians to provide the highest quality care. Furthermore, CQI offered an alternative to traditional quality assurance (QA) processes that review inadequate treatment outcomes (outliers) retrospectively and identifies individuals associated with those outcomes. CQI is based on an assumption that the system, not individuals, is more often the

cause of poor quality. Participating on teams using CQI rules to improve clinical quality is a scientific method to enhance patient care, a positive approach that is preferable to the negatives that physicians associate with QA (James, 1991; Kritchevsky & Simmons, 1991). Berwick (1993) could not have been more emphatic in his exhortation to physician colleagues to embrace the CQI philosophy:

> Just as the Flexner Report of the early 20th century called us to a new identity as scientists, so does the decay of excellence in the healthcare system call us now to a new identity: doctors to the system of care . . . . You have the task of learning new skills that you largely missed in professional training, and then trusting enough in those skills, yourself and others to get started on changing and improving the work you once so proudly began (pp. 9, 10).

In one important sense, hospital reform leaders seeking to increase physician involvement in the process were fortunate that a new development in medical practice was emerging independently but simultaneously with the CQI movement. I refer here to the movement to create standardized best practice care plans most commonly called critical paths (CP), also known as clinical pathways or practice guidelines. A CP is a step by step outline of the activities that should occur in the treatment of a specific condition from the pre-admission stage, before, during, and after the medical intervention, through the patient discharge plan. The vast majority of CPs are developed locally (as opposed to commercially or medical specialty board prepared CPs) by teams that are necessarily multidisciplinary in nature (Hoffman, 1993; Lumsdon & Hagland, 1993).

CPs were originally developed in industry (in the engineering

and construction fields) in the 1950s to assist in project coordination activities, and were first used in medicine by nurses in the mid-1980s. In the late 1980s, the use of CPs in medical care was encouraged by governmental funding sources, medical organizations seeking to control costs by standardizing practice, and by medical association leaders who believed the approach could produce higher quality medical care. Physicians were not especially enthusiastic about CPs originally, and viewed this approach disdainfully as "cookbook medicine."

CQI leaders were quick to recognize that the goals of the CP movement, the data analysis process that is fundamental to the development of a CP, and the use of teams in the creation and implementation of a CP replicated the intentions of the CQI approach. Berwick (1992) called CPs "a first cousin" to the CQI movement; others simply began calling CPs clinical CQI (Inpatient case management, 1992: Hart & Musfeldt, 1992). The New York State Health Commissioner suggested that "it might well be true that implementing practice guidelines in the context of CQI is the best way to use this technique to improve quality" (Chassin, 1993, p. 41).

CPs, that is, clinical CQI, was easier to sell the physicians than anticipated for a number of reasons. In the first place, it was directed toward improving patient care and that made it seem a world apart from the administrative process concerns that most interested management who first learned about CQI in its industrial context. Second, as it worked out in practice, CPs were not so rigid as feared. Built into the approach was the

logical and necessary option that a physician's order could override any step in the CP when circumstances warranted it. Third, although developing a CP took time, its implementation actually made the physician's life easier. The physician no longer had to worry about every routine step in the patient's care plan; the patient's caretakers knew what to do when to do it because it was already delineated in the CP. Finally, as data on the effects of CP case management became available, it was clear that the results were positive: morbidity, patient length of stay, and costs all declined when this approach was used. Critical paths, it seemed, made it possible for physicians to play an important role in achieving key goals in healtlhcare reform (Gloger & Tovar, 1993; Healey, Loukota, Sears, & Miles, 1994; Lumsdon & Hagland, 1993; Richards, Sonda, Gaucher, Kocan, & Ross, 1993; Roche & Lawrence, 1993; Weber, 1992).

Implications for Educational Reform

Defining shared decision making as the essential component of contemporary organizational reform results in a pessimistic assessment about the probability of restructuring schools successfully. The studies cited earlier confirm Betty Malen's observation that with regard to SDM "it's real hard to find locations . . . where the reality meets the rhetoric" (Bradley & Olson, 1993, p. 44). In contrast, enthusiasm about hospital reform is still high as evidenced by the successful results that continue to be reported in the literature (Freedman, Mapa, & Droppo, 1994; Pehrson, 1994). Involving physicians in shared

decision making through the use of critical paths is a trend that is escalating not declining.

An explanation for these opposite directions is not difficult to discern. In practice, SDM in schools has "only occasionally" given teachers an opportunity "to become involved with decisions that they care passionately about" (Midgley & Wood, 1993, p. 251). As has been shown, this is not the case with physicians in the specific and crucial role they must play if healthcare reform is to succeed. Even though there are important differences between the professions of medicine and education, the conditions that prompted physicians to become engaged in the achievement of quality driven hospital reform goals are instructive for educators. They suggest that a way must be found to reorient shared decision making activities to things that matter to teachers. Otherwise it would be an intelligent and humane gesture to hang a "do not resuscitate" order on that body of ideas called school restructuring that seemed so full of life just a short while ago.

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